



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Consultants in Pain Medicine

Respondent Name

Travelers Indemnity Co

MFDR Tracking Number

M4-17-2846-01

Carrier's Austin Representative

Box Number 5

MFDR Date Received

May 25, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In review of your explanation of benefits, it seems that you denied claim in error. Code 80307 is a new code that replaced G0479."

Amount in Dispute: \$98.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider alleges they are entitled to reimbursement for the services at issue. The Carrier has reviewed the Medicare base rate and calculations utilized and determined that the Maximum Allowable Reimbursement was properly calculated, as the services in dispute are included in the Medicare base rate for CPT code G0480 reimbursed under this date of service. The Carrier contends the Provider is not entitled to additional reimbursement for the disputed services."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 22, 2017	80307	\$98.85	\$76.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:

- 97 – payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- P12 – Workers’ compensation jurisdictional fee schedule adjustment
- 45 – Charge exceeds fee schedule/maxim allowable or contracted/legislated fee arrangement
- 309 – The charge for this procedure exceeds the fee schedule allowance
- 6578 – Individual laboratory codes which are part of a more comprehensive laboratory panel code were reimbursed at an all-inclusive panel code. All other drug screen codes are included in the reimbursement for the reimbursement for the comprehensive laboratory code
- W3 – Additional payment made on appeal/reconsideration
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
- 947 – Upheld, no additional allowance has been recommended

Issues

1. Are the insurance carrier’s denials supported?
2. What is the rule that applies to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking reimbursement for services provided on February 22, 2017 in the amount of \$98.85 for the following:

Procedure Code 80307 – “Drug test(s), presumptive, any number of drug classes, any number of devices or procedures, by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service” and

The insurance carrier denied disputed services with adjustment reason code 97 – “Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.”

28 Texas Administrative Code §134.203 (b) states in pertinent part,

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

- (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers;

Review of National Correct Coding Initiative Policy Manual, Chapter 10, Pathology / Laboratory Services, CPT Codes 80000 – 89999 found at www.cms.gov finds the following:

Beginning January 1, 2017, urine drug presumptive testing may be reported with CPT codes 80305-80307. These codes differ based on the level of complexity of the testing methodology. Only one code from this code range may be reported per date of service.

Beginning January 1, 2016, urine drug definitive testing may be reported with HCPCS codes G0480-G0483. These codes differ based on the number of drug classes including metabolites tested. Only one code from this code range may be reported per date of service.

Based on the above, the Division finds there are two separate services that have no CCI edits. Therefore, the carrier’s denial not supported. The services in dispute will be reviewed per applicable fee guideline.

2. 28 Texas Administrative Code §134.203 (e) states,

The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

- (1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,
- (2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

Review of the 2017 Clinical Diagnostic Laboratory Fee Schedule finds no separate allowance for the professional component. Therefore the maximum allowable reimbursement will be calculated per 28 Texas Administrative Code 134.203(e)(1).

The fee schedule amount found in 2017 Clinical Fee Schedule at www.cms.gov for code 80307 is \$61.02. This amount multiplied by 125% = MAR of \$76.28.

The total allowable is \$76.28. This amount recommended.

3. Based on requirements of Rule 134.203 the amount payable is \$76.28. The carrier previously paid \$0.00. The remaining balance of \$76.28 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$76.28.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$76.28, plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	June 16, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.